MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
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RALPH W. MULLER
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JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Medicare spending compared to other health spendingindicators -- Anne Mutti, Ann Marshall

MS. MUTTI: This topic today is a second installment in a series of presentations that are intended to give you a broader sense of Medicare spending patterns. Last month, as you might recall, we talked about fee-for-service spending, both historical and projections, and how that spending was divided by service sector.

Today, we will be talking about comparing Medicare spending trends, compared to other health spending indicators, and we hope this information will be useful in thinking through the appropriateness of spending trends, the adequacy of Medicare's payment and coverage policies, and Medicare's effectiveness at controlling costs.

In today's presentation, it will be sort of a three-parter. We will start with how Medicare compares to other payers in dollars spent, both how much and on what, and then we'll talk about growth rates, how Medicare and other payers compare in their growth rates. And, lastly, we will look at the different factors driving those growth rates, but first a few words to caution us in this endeavor.

With respect to the Medicare projections, first, throughout this presentation, we will be using the Medicare trustees' intermediate assumptions as the basis for the data that we present before you. You must bear in mind that these projections assume current law. So that even though certain provisions are set to expire that will lower spending, we assume that that lower spending will be achieved, even if that is maybe unlikely, given Congress's inclination to change it.

Then, it also points to the greater issue of the uncertainty around these projections. The trustees do high, medium and low estimates. Here, we are using their intermediate, their medium estimates, but there is certainly some variation or a difference of opinion as to what really will happen.

On the next point, we also point out that the projection data that we are using, especially when we are looking at national health expenditure data, ends at 2011. This is just prior to the retirement of the baby boom generation. So just bear in mind that probably beyond that point or, definitely, we are going to see spending increase.

When looking at some of the private sector numbers that we are going to show you, we just also want to alert you to the fact that premium growth may be somewhat sort of depressed or suppressed because we are seeing a trend of insurers moving more of the total cost of their benefit package to beneficiaries, in terms of cost sharing. So their premiums may not be increasing as much as really the

total cost of the benefits are increasing.

Lastly, we just want to point out the somewhat obvious point that Medicare beneficiaries are older and sicker than other insured populations, and this will certainly affect the level of spending and also may affect growth rates a little bit.

So, first, we wanted to refresh you on the size of Medicare and how it compares with other payers of health care services. In 2000, Medicare comprised 19 percent of all personal health care spending. Personal health care spending refers to the spending directly on services. It excludes research, construction, public health spending, administrative costs, things like that.

Medicare spent about $224 billion or about $5,600 per beneficiary in 2000. When you are looking at this chart, it might help you to bear in mind that out of pocket includes co-insurance, deductibles, co-pays. It does not include premiums. The premiums are implicit in the private health insurance section of the pie, as well as the Medicare section of the pie. Overall, 43 percent of personal health care spending was from public sources, while 57 percent was from private funds.

On the next chart, you can see this is our attempt to compare Medicare spending and how it is spent over service sectors compared to that of other payers. We have highlighted the Medicare and Medicaid and then lumped everybody else together, just so you can really focus on the Medicare numbers.

As we just mentioned, Medicare comprises 19 percent of personal health care spending overall, but when you look here at the hospital line, it paid for about 30 percent of all hospital services. Its spending was about 28 percent of all spending for home health services and about 25 percent for DME.

In contrast, Medicare paid for about 2 percent of Medicare spending, comprised about 2 percent of prescription drug spending, virtually no portion of dental spending and a very small or relatively small portion of nursing home care.

MS. MARSHALL: We had a data correction on the actual chart. So the figures that she just cited are correct, and the chart that is displayed is correct. The one that was handed out to you previously, like that has 20-percent for hospital, is not. So we apologize for that. It was corrected late yesterday.

MS. MUTTI: So next we turn to sort of the second part of this, which is examining growth rates and making a comparison.

First, we are looking here at personal health care spending as a percent of GDP, and then on the next chart we compare that with Medicare as a percent of GDP. We are

doing it on two different charts because the scale is so different, and we have different windows of projections here for you.

We chose to make this comparison, in terms of percent of GDP, to give you a sense of how fast health care is growing in relation to the economy.

As you can see here, after a relatively stable period through much of the 1990s, personal health care spending is projected to increase from about 11 percent to over 14 percent of GDP by 2010.

On the next chart, we see much of the same upward trend line with Medicare as a percent of GDP. You can see sort of the spike and dip that's concurrent to the enactment, just prior to enactment of BBA and afterward, the decline there. This chart also shows that after 2011, the effect of the baby boomer generation increases spending in relation to GDP, so that by 2030 Medicare is expected to be about 4.5 percent of GDP, nearly double what it is now.

Next, we compare per capita growth of Medicare spending to per capita growth of private insurance spending.

As you can see, while there are different divergences, growth in the two have been roughly comparable since 1980. Looking at current growth estimates, we see that private insurance is expected to outpace Medicare in the short run, and even employee benefits consulting firms have suggested that there will be even higher premium increases. They show in the range of 12 to 16 percent in this year and next year, so these estimates may even be on the low side.

By about 2005, private insurance -- this is just a projection -- is predicted to grow just slightly faster than Medicare. The divergences between the growth rates are attributable to a health insurance underwriting cycle and other trends in the private market that occur at different times than the major legislative changes that are affecting Medicare.

So you can see, for example, Medicare spending growth rates were high prior to the BBA and then dramatically dipped, so much so that we even saw a decrease in 1998. And in contrast, during this same period, private insurance annual spending growth rates were relatively steady around the 5-percent mark.

As I mentioned earlier, you might want to bear in mind that many private insurers are increasing their cost-sharing requirements so that their premium growth may not be, in a way, is somewhat depressed. We also want you to bear in mind that Medicare spending reflects current law, as we mentioned before.

DR. ROWE: Could you explain that? Why is it that if cost sharing is increased -- which I think, actually,

it's not the private insurers that are increasing cost sharing so much as the employers, so I see that differently than you -- then why would that reduce the private insurers' premiums?

MS. MUTTI: Because it's my understanding you would not need to increase your premiums at such a fast rate if you were able to sort of deflect some of your increased total costs by raising cost sharing. So you would have to build it into your premium.

MS. ROSENBLATT: Jack, suppose you get a 15-percent increase on a plan, a PPO plan with a $500 deductible, and the employer changes the deductible from $500 to $1,000, the 15-percent increase might then become 12 percent.

DR. ROWE: I understand completely. I just think it matters whether, by increasing cost sharing, you mean the same premium, but the employee is paying a greater proportion of it or whether you mean --

MS. MUTTI: No, cost sharing, I meant in terms of deductibles, and cost --

DR. ROWE: -- benefit, high-end changes, and that was what I was referring to.

MS. MUTTI: Thank you for the clarification.

On the next chart, we have compared Medicare per capita growth to that of other large public purchasers, CalPERS, FEHBP and Medicaid, for the last 5, 10 and 15 years. At this point, I'd like to just caution you that I think these are somewhat preliminary. We are going to come back and revisit just to make sure that we are really comparing them as accurately as we can. So these are somewhat preliminary numbers.

As you can see, the last five years of Medicare spending is so low, due to the BBA, that Medicare is considerably lower than CalPERS and FEHBP. However, when you look over the 10-year window, Medicare's growth is much more in line with CalPERS and FEHBP. The 15-year window catches some of the high private-sector growth of the late '80s/early '90s, making their growth rates higher over that time period.

Medicaid is also here on the slide, and we just would note that their growth rates tend to be influenced by factors that are sometimes unique to Medicaid in terms of the disproportionate-share payment policies and the upper-payment limit policies. So it may reduce somewhat the usefulness of that comparison, but we still provide it here for you.

MS. DePARLE: Anne, are prescription drugs in FEHBP, and CalPERS and Medicaid?

MS. MUTTI: Yes.

MS. DePARLE: So do you have any idea what it

would look like if you backed that out of it?

MS. MUTTI: Sometimes I think I have heard people say that a certain percentage is associated with that, but I don't have that. I can find that out for you.

DR. REISCHAUER: Marilyn Moon tried to do this in one of her papers and make some impact, but not an immense.

MS. MUTTI: Then here's the third part. We're examining the factors here that are driving growth and spending, on personal health care spending. We start at the bottom of this chart. You see the population growth is one factor, and it's remaining relatively steady.

Next up is economy-wide inflation, which was a big driver in the 1980s and then has settled into the 2- to 4-percent range more recently.

Medical inflation, which is inflation above general inflation, fluctuates some and is a relatively small factor in the mid-'90s. As you can see, at times, volume and intensity rivals inflation as the prime driver of growth, and this was particularly the case in the late 1980s, before managed care expanded and curtailed some of that growth. We are working on actually getting a companion chart to this which would just give the factors for Medicare, but we don't have that at this point.

The next slide compares growth by service sector between Medicare and private health insurance between 1995 and 2000. As you can see, Medicare growth during this time is really largely due to growth in hospital and physician spending, in contrast, and as Nancy-Ann pointed out, we see the role of prescription drugs driving the increase on the private side, as well as hospital and physician spending.

Just a note on the Medicare side, the negative portion in the Medicare bar reflects a decrease in home health spending over that period and explains why the bar tops out of over 100 percent there.

A similar analysis of the contributing factors to private insurance growth was recently published by Strunk and Ginsberg. They found a higher percentage of change due to hospital spending increases. I'm not exactly sure. We used national health expenditure data, had a few methodological differences, but I'm not exactly sure what explains why we came up with such differences on that. They used a different data set than we did, though.

So we look forward to your feedback on the substance of this presentation. Certainly, in the next few months, we are going to be working at making sure that we've got all of our numbers right, bringing in some other sources, so that we are not relying exclusively on national health expenditure data to give you a sense of what the projections look like, and so we just look forward to your feedback.

I just also want to give you an idea of where we are going to go next on this. This is sort of a series of information that gives you the broader sense of Medicare spending. Next, we hope to talk to you about how Medicare spending fits in with the overall budget, and deficit, and surplus projections, and then also look at how Medicare spending trends affect beneficiary cost sharing and what the trends are in that too.

DR. REISCHAUER: I thought there was a lot of interesting stuff in here, but I wasn't exactly sure what question we're trying to answer. Not knowing that, I felt there was some confusion here, and let me give you just a couple reactions I had.

Throughout the paper there is a lot of discussion or reference to the 1997 through '99 period and the slowdown in Medicare spending that attributes everything to the Balanced Budget Act, when in fact there was a lot else going on, not the least of which was the crackdown on inappropriate payments by the Justice Department, the IG and others. So I would dampen that down.

With respect to the discussion about spending as a percent of GDP, I think you want to point out that at least or a very large component of that was because the economy grew like gangbusters, as opposed to the reduction in the growth rate of spending. I mean, both things were going on, but the denominator was going berserk in that period. So let's not treat it sort of is this is a story about health care as much as it is about health care and the economy.

There is a certain amount of contamination that is going on here. If the question is sort of how is this insurance program for the elderly/disabled doing versus the insurance program that covers other kinds of Americans, and that is because Medicaid is, a significant fraction of that spending is for Medicare-eligible people -- I mean, over half. The private numbers, I think, include supplemental policies for Medicare-eligible people and employer-sponsored wraparounds, which are a component. If we are trying to look at these as separate, there maybe is some way we can ferret them out.

The final point or concern that I have has to do with us going along blindly with this notion that medical inflation is somehow over and above economy-wide inflation. And, Joe, in his paper, has a really nice three pages basically explaining why you shouldn't believe that at all. It's mismeasurement more than anything else. And I wouldn't want us to be contributing to the "common belief" that we know for a fact that the health care inflation is above economy-wide inflation because I suspect appropriately adjusting it for quality and reweighting it, in fact, the opposite is the case.

MS. ROSENBLATT: I too found this to be excellent. I'm not sure where it's going but I think we might know as we get additional analyses.

I do have a couple of comments on dives that I would like to take, if the data is available.

The most interesting chart to me, and I don't have page numbers on this, but it's the one per capita spending growth in Medicare and private insurance, going from 1980 through 2010, where you have got it Medicare versus private health insurance. Yes, that is the one.

A couple of comments on that. I would love to see this broken down by service category. So, if you could do that, and my guess is you can't, but if you could look at hospital growth in the private commercial sector versus hospital growth in the Medicare sector, and physicians, et cetera. Again, I don't know if there is a way to do that.

The other thing is I've got a comment similar to what Bob just said, that if we could dive down into separate the commercial premium out from the commercial population under 65 versus Med supp, and if we can't do that for the retirees connected with employers, if we could at least do that for the retirees that buy it as individuals. And then if we could separate the M+C out of the Medicare, that might all might be interesting as well.

The paper did a good job of describing some of the influences on the premiums, like the cost shifting that we were talking about with Jack before. One of the things that is also influencing, particularly over this long time frame, is shifting between types of plans, like from HMO into PPO or indemnity into HMO. So I think you might want to mention that shift as well.

We talked earlier today about the concern of projections. I am concerned about using the intermediate growth assumptions from the trustees' report, and I'm very concerned about using those projections out to 2030.

I think that is it. Thank you.

DR. NEWHOUSE: I'm assuming this is a stage-setting and descriptive chapter, and so the comments on it are not the most important comments we'll have over the course of the session, but let me throw in some anyway.

There's a few of my pet peeves have arisen here. One is trying to project spending, especially many years out. I don't think we have been very good at that, historically. The trustees have to do it by statute, we don't, and my preference would be just that we don't present somebody else's projections or, if we do, we present several other people's projections. I think it has a large element of crystal ball gazing in it.

Second, on the slide that is up there and

elsewhere in the chapter, I don't think it makes sense to compare spending across time in nominal dollars. If you, for example, look at those, the peak of this curve in 1980 there, on the far left, that is an era of very high general inflation rates, and I think that should be taken out if we're going to try to compare 1980 with 1990 or any other year. In other words, the fluctuation in general inflation may be obscuring some things that one would want to see.

Third, I have never liked the CMS classification that's on the Slide 2 charts, hence about volume service use, medical inflation economy-wide and population, for a couple of reasons, one of which Bob said. I don't think we measure medical inflation at all well, especially historically. But another reason is that this seems to underplay, in its language, really, it's really a semantic issue, the role of new products, technological change, old procedures in new populations, which the text lays some emphasis on, but this discussion makes it sound as though it's population grew, providers raised their prices, and they just gave more services to the same folk or the same old services to those folk.

I think I would just not use this. I don't see any reason why we need to use that. I think you can have a discussion of how new products and kind of existing procedures in new populations, especially the very old, have tended to raise spending. That, by the way, also obviously complicates the measure of medical inflation because inflation really has to be defined for a specific product. The price of that product over time. If the product is changing, then there is a major conceptual problem trying to say what inflation is.

Finally, the discussion that compared the private side with Medicare, I didn't see why we were comparing private premiums with Medicare spending. I thought we should be comparing private spending with Medicare spending or Medicare and Medicaid spending. The CMS numbers have private spending, and I don't know why we just didn't use those instead of premiums.

MS. MUTTI: We went back and forth on that and we can easily add that.

MS. ROSENBLATT: Joe, when you're saying spending, are you saying take the sum of the premium -- the amount spent on claims in the premium with the amount that the employee spends for co-pays?

DR. NEWHOUSE: Yes, I'm talking about basically spending per capita on the privately insured or the non-public, if we want to include the uninsured.

DR. ROWE: Are you including the SG&A expenses or are you just including the claims payments?

DR. NEWHOUSE: It's not going to make a great deal

of difference, but you can throw in the SG&A on the privately -- it's not going to make a great deal of difference the total spent per person, but you can throw that in if you --

DR. ROWE: No, I just wanted to know what --

DR. NEWHOUSE: I thought about that. Yes, in principle, that should be included.

MS. ROSENBLATT: I'm not familiar with the various data sources that the staff would use, but the employee is only picking up 20 percent. So, when you say per capita spending, is it --

DR. NEWHOUSE: Well, there's also non-covered items. If you look in the national health accounts, there's a total for public sources, and there is a total for private sources that is broken down between out-of-pocket payments and third-party payments. Indeed, it's implicit in that pie that's up there for everybody. There is a similar breakdown for private -- and that's what I had in mind comparing. It seems to me that's a much more apples-to-apples number than private premiums against total public spending.

MS. ROSENBLATT: Okay, that's similar. That other chart, when I said I wanted to see it split out by hospital versus physician, I guess I'm asking for the same thing.

MR. FEEZOR: Being a subject of some of the scrutiny here in a couple of comments, first off, I think Anne and her colleagues did a good job in trying to put together otherwise rather disparate comparisons.

A couple of words of caution. One, I don't know too many people that would consider CalPERS or the FEHBP program to be typical of private payers. So we should not refer to it as private, but rather other public employment-based coverages.

I think it is critical that we probably give a little bit more analysis to the types of coverages that are employed, and particularly what that may do in terms of the burden to the individual. As an example, we have 80 percent/78 percent of our folks in insured HMOs, and that is to say we use a flat co-pay and have had the same flat co-pay for 10 years, until last year. Whereas, other forms may, in fact, be co-insurance, which may rise more traditionally with the rise in cost.

Also, I think when we start talking about employers shifting costs to employees, this can be borne out, but my sense is that that really has only become a significant factor probably in the last two to three years, from about 2001 on; that, in fact, in most areas I think a relatively tight labor market and relatively modest increase in insurance premiums have caused most employers to maintain their coverages, at least until through about 2000 would be my guess.

We may want to see if there is some way of indicating if that has increased. I think it is increasing now certainly in terms of the products being sold.

DR. ROWE: Allen, let me comment on that, if I can. I think, actually, if you look at the period of time that is covered by that slide that began 1980, during that period of time the overwhelming trend, particularly in the early part, is for the employee to pay less.

MR. FEEZOR: Yes, in fact ours dropped rather noticeably, and that is what --

DR. NEWHOUSE: Actually, it's been constant in that period. Hospital costs actually goes up in that period; physician comes down and drug.

DR. ROWE: I thought that in terms of, well --

MR. FEEZOR: In terms of burden of total expenditures borne by the individual versus their plan, at least our experience has been there ha been a significant shift away from the individual and to the plan, and then it depends upon your employer/employee contributions towards premium, in terms of what the total impact of that is.

DR. ROWE: I agree.

MS. ROSENBLATT: I'm sorry, could I interrupt? This discussion would say that another good historical chart would be to show that percent of cost sharing, which I think we may have looked at in the past, for Medicare versus the commercial population.

MS. MUTTI: Absolutely, and that was sort of our inclination, when we were first looking at it, at least, and I will go back and probe this a little further, but the way the NHE reported it, it was all out of pocket, it was lumped together, and I couldn't separate Medicare from other private, which thwarted us on that, but I will keep looking.

MR. FEEZOR: Then the final thing. I think the paper tries to touch on it, and I don't know, it would be an interesting question, whether the change in the benefit package itself, whether the Medicare benefit package is likely to change and enrich faster than say that of insured coverages. Again, because we use, at least up until this year, use 80 percent of basically traditional HMO products, which are subject to state regulation, that the issue of mandated benefits has been considerable on that.

And so I can say we had a 3 or 4 percent bump about three years ago, two years ago, for instance for nervous and mental parity and other issues. So I think we probably need to at least try to give some account to that.

And then I guess the final issue, and I'd have to go back to some folks, maybe Alice can help me or Jack. Are the plans within the FEHBP program able to modify their own benefits from time to time each year? I was thinking that's the way it used to be.

DR. REISCHAUER: They get approval from the negotiations with OPM.

MR. FEEZOR: Having said that, and we've got a couple of other things, we do have about 30,000 people that are outside of California.

The paper does bring up that particularly when you're looking at CalPERS figures, the geographic concentration of our enrollees in California, which may be a little bit of a different market, is important to keep in mind, as well.

MR. MULLER: If I can go back to the 30-year slide again on Medicare and private, and I think this just makes the point that Joe was making earlier about the difficulty of projections. Because if you look at the first decade, you have quite a few spikes up and down but basically in the cycle, in the '80s. Then in the '90s, you have countercyclical, and we've commented on that in the past, with private and Medicare moving in different directions.

And now our projection basically shows no spikes and moving together, which not what happened in either one of those decades.

I understand why people regress towards the mean, but it may be useful if we're going to get in the project game based on the conversations we've had, is to also show this with spikes both cycling together and spikes cycling countercylically. Because obviously, if one thinks, as a matter of policy, that the trend of the last 10 years of the private and public sector moving to balance each other somewhat is going to occur again, then one has much different budgetary implications than if one thinks you're going to go together.

The likelihood of them going together, I understand why one does that for projection, but it's probably the least likely one to come out. The fact that we're going back to the '80s -- and I know you're reflecting someone else's estimates here -- but I would like to at least, in the spirit of showing a range of estimates, to show both the countercyclical estimates and the ones with the spikes.

Thank you.

MS. ROSENBLATT: If I could just tack on to what Ralph just said. I think that first dip for the private health insurance is 2003, if I'm looking at the graph right. And I don't believe that for a minute.

MR. DURENBERGER: This question, Mr. Chairman, is out of ignorance but it goes back to, I think, a question that Bob Reischauer raised and it's all excellent data, but it's to what end? And if I go back to the issue involved here, the reason we're doing this it says is to help policymakers assess the factors driving Medicare spending

trends. And that's a little bit where I'm not focused.

I'm trying to figure out what information about the cost drivers or the trend drivers comes out of this and what is coming out of other things that we're doing. This is just a context for other things that we're doing. It seems to me the most important part is what are the cost drivers, either historically or currently or projected or something like that? And how do you express those against the dollars that you see here?

And I'm not quite getting, out of this information -- the medical inflation one is a good example, but I'm sure there are breakdowns within that context that I don't see here. I just have difficulty putting this in appropriate context.

MS. RAPHAEL: I guess in line with that, trying to understand what we can glean from all of this, besides the difficulty of making projects, from what we see here the ability to sort of suppress costs in the Medicare program have been attributable to legislative action and investigations of provider behavior. Those are the two things that led to cost drops.

From what I can see in the private health insurance market, the main cost drops have been due to shifts of costs to employees.

MS. MUTTI: And also managed care.

MS. RAPHAEL: And discounted payments, right. I mean, I'm trying to sort of figure out what we can draw from all of this. Are there any other preliminary conclusions that you can draw at this point, when you put this all together?

MS. MUTTI: We were trying to avoid actually coming to conclusions. This was supposed to be everybody put this in your head so when you're making your recommendations you just bear in mind. I think it's for others to put a finer point on this, but from my perspective I think it's helpful to know how fast, just in general, Medicare is growing and how fast it's going to grow and comparing that to the private sector, just as a check to see how are we doing? Are we in line with other people? There are certainly differences accounting for different growth rates.

But it just seems to be a useful check, if we saw really dramatically different trends. And this might come out more in some sector-specific analysis that we did, rather than this aggregate number. But if you saw that Medicare was going up really high for one sector over another, compared to private insurance, that might tell you something.

At this point, we're not trying to tell you what to glean from it. We're trying to collect that data. You

could use this, it could inform you on a lot of different levels. It just seems like a good thing to have in the back of your head.

But as I say, I think we'll probably put a finer point on --

MS. RAPHAEL: I don't know if I understood this. It seems that hospital and physician costs are a greater factor in Medicare growth than in the private insurance market.

DR. ROWE: Because there's no pharmaceuticals.

MS. RAPHAEL: Do you think that that can be the conclusion we draw?

MS. MUTTI: Right, there's no drugs. I did do the quick math on them. They represent a faster portion of the growth than they represent in spending.

DR. ROWE: It's 13 percent of spending but it's 44 percent of the growth.

MR. MULLER: So the indication is that if you have drugs you have more ups and downs?

MR. HACKBARTH: We need to keep moving ahead here. I think Dave has asked a very important question, and I have a reaction to that. But Alan, why don't you go first?

DR. NELSON: I was going to try to answer Dave's question. As I remember, we asked for this. As I remember, we were talking about projected Medicare spending and we decided that we couldn't deal with that in a coherent fashion without some understanding of both the previous trends and what was expected in the private sector. So we asked that to put together some material that would allow us to make some comparisons.

Joe, you said something that interests me, and I wonder if there's any further clarification on it, that previous projections hadn't proven to be terribly accurate. Can you give me some brackets around how inaccurate they were? I mean, what's the confidence level on these projections based on earlier experience?

In 1980, you looked at the projections that were made in 1980 for spending in 1990, or '85 and '95. What was the experience?

DR. NEWHOUSE: I can't give you numbers but I was thinking of something that Louise Russell did several years ago where she did go back and look at the trustees' projections and then map them against what happened. And my recollection is the actuaries didn't look too good. And for sure people missed the '97 to '99 drop or plateau. I mean, nobody was predicting that. I mean, thank of all the rhetoric about the BBA "overshot."

I mean, one can argue with that assertion, but at bottom it was that people weren't expecting what happened.

DR. REISCHAUER: With all of these projections you

can't go back and blame the projectors because policy changes --

[Laughter.]

DR. REISCHAUER: I'm innocent.

DR. NELSON: It's not a matter of blame, Bob, it's a matter of reality. I mean, you just made my point. It's not a matter of blaming them for lousy projections. It's that it's impossible to anticipate all the variables that are going to come in the future. And that gets back to Joe's point, don't get into that business.

DR. REISCHAUER: But both things are going on.

MR. HACKBARTH: We need to move on in just a minute, but to me the most interesting thing about data like these is trying to answer the question what, over the long term, drives the increase in health care costs in general and for Medicare in particular? What are the forces that policymakers need to wrestle with?

It's not the individual, year to year variation, or certainly not the long-term projection. But what are the underlying forces? And Joe's made a couple of interesting observations in that regard about what we label volume and intensity and medical inflation.

I think sometimes, maybe hopefully, we say well, it's driven by factors like ease. And we can get a grip on medical inflation and unwarranted volume and intensity. But in fact, I think a big part of that is the unrelenting increase in technology and new ways to do things for more people. And that means getting a grip on this poses very difficult choices about what, as a society, we're willing to pay for.

I would like to try to draw some of those fundamental questions out of the data, as opposed to just report lots of data.

MR. MULLER: I think one could also argue, looking at this slide, that both private parties and government took steps in the last 10 or 12 years to change the reality that the projections indicated. So you could, in a sense, interpret the '80s as kind of saying expenditures are flowing due to those kind of underlying charts, medical inflation, population, et cetera, and so forth. But the '90s was an effort, you could in part argue, whether it was the BBA efforts or the fraud efforts or the managed care efforts, to make some change in the projections.

So in a sense, as one makes projections, one can therefore also assume that somewhere between government and private -- and they're not just two entities -- that some change will occur.

My concern is just that middle line, the kind of driving down the middle of the road, it's just not going to happen. That's why I'm a little concerned about putting

that kind of forecast out there. But I would assume with numbers this big that interested parties will take policy actions to change what the projections would otherwise imply.

MR. DURENBERGER: Can I just add to what you said? My only concern is to educate policymakers and I don't think these numbers do. Probably a lot of the rest of our work will, or getting behind the consistent cost driver, getting past aging and technology misused and defensive medicine and the consumers not paying with their own money, getting to some of the real factors in addition to that that drive costs consistently, like all the transaction costs in health care generally, the way we practice, and those kinds of things.

That's what I see, I guess, as the desperate need by policymakers, because they're plain old citizens like us, that's the part they need to understand. This sort of thing, in some context, is part of their job. But what causes these things consistently to happen? And why is it that when you do '97 to '99 it's going to be followed by a '99 to 2002? And it will continue to happen because that is the behavior that we've seen consistently in the current health system.

So when we get to other things that are on this agenda, I think we're probably getting at some of those kinds of issues. I hope I'm not way off the wall, but I'm just really trying to get at what are these cost drivers that are not dealt with simply by increasing or decreasing the chase for fraud and abuse or the physician payment reimbursement or some of those kinds of issues.

MR. HACKBARTH: This was thought-provoking, Anne, and we'll have more on it later. Thank you very much, both Anns.